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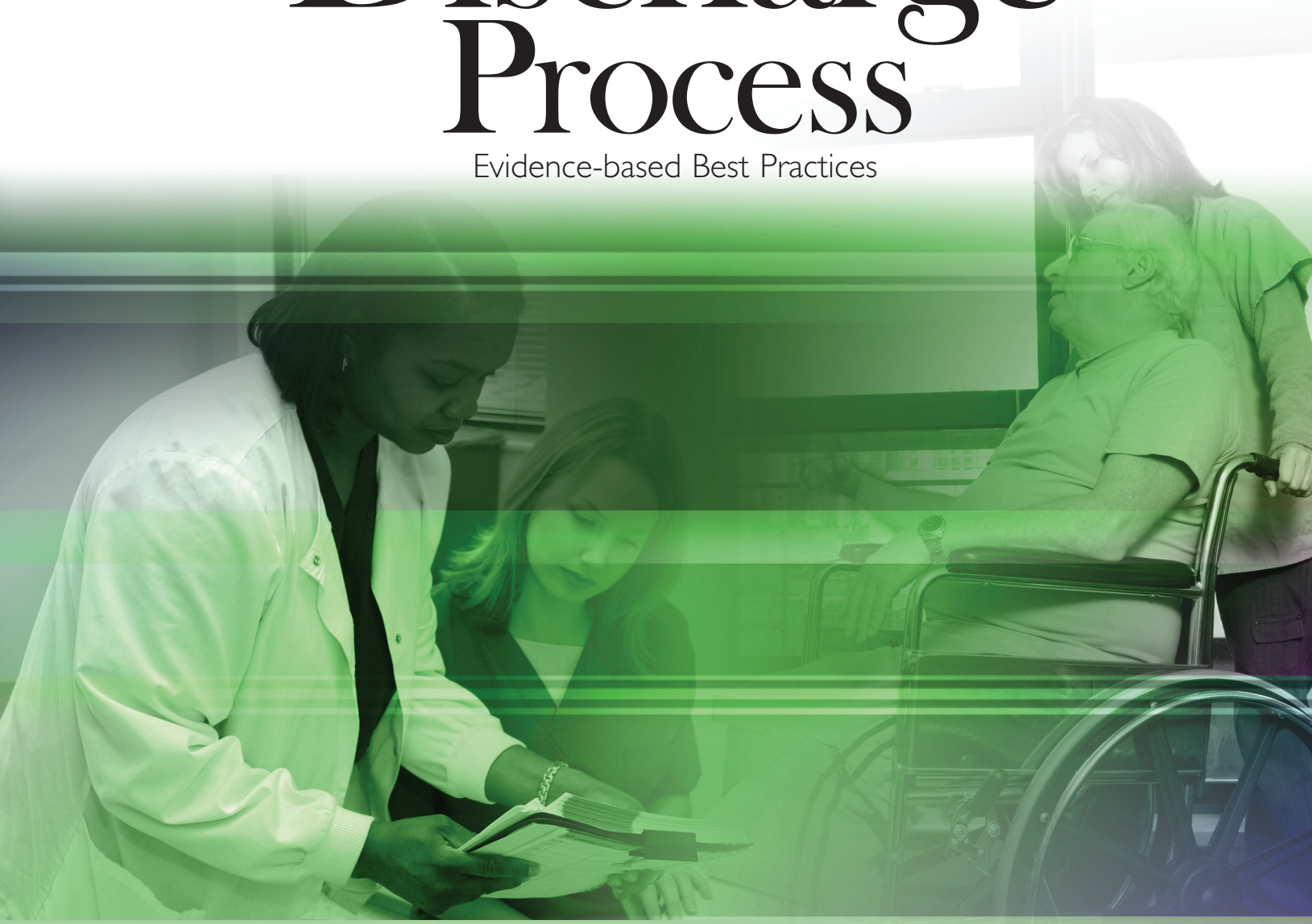
# Patient Satisfaction and the Discharge Process

## Evidence-based Best Practices



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# CONTENTS

# What the data says: Going home from the patient's perspective

Going home is perhaps the most welcomed, appreciated, and greatly anticipated event in a hospital stay. Take a moment, close your eyes, and think about **your home.** Think about your loved ones, your comfortable bed, your pets, and your home-cooked food. Consider the familiar surroundings that make you feel relaxed, comfortable, and happy. Home is the place that grounds you. It is a place where you don't have an unfamiliar roommate, hall noise, 3:00 a.m. blood draws, or metal bars along the sides of your bed. After considering this, you can understand why patients' desire to go home is so strong. We all would rather be home than in a medical facility.

Nevertheless, going home doesn't happen instantly after the pain subsides. Getting patients to the point where they can physically manage on their own, arranging ongoing care, and helping patients and family understand what they need to do are all part of going home. This is typically a complex, interdisciplinary, multi-organization process.

Patients evaluate this process based on four distinct elements. Press Ganey identified these elements through ethnographic and qualitative research by developing survey instruments to measure patients' satisfaction with their experience of care and then testing these elements

against rigorous psychometric standards.[1] Broadly conceived, these four elements are as follows:

1. **Patient's personal readiness.** Do the patient and family feel that they have the appropriate understanding, confidence, and capacity to manage at home? Patients with serious concerns about their own ability to manage typically will have real issues that need to be addressed.

2. **Speed.** Is the process of getting the patient home efficient?

3. **Instruction.** Do patients and family members know what to do after they are discharged? Was patient education regarding self-care, therapy, medication, and other issues effective?

4. **Coordination of arrangements across the continuum.** With our aging population, more patients now require home care services, medical equipment, rehabilitation care, and other health services postdischarge. How well were these arrangements made and communicated?

Four specific points that comprise the discharge section of Press Ganey's Inpatient Satisfaction Surveys explicitly measure these broad concepts:

1. Extent to which you felt ready to be discharged
2. Speed of discharge process after you were told you could go home
3. Instructions given about how to care for yourself at home
4. Help with arranging home care services (if needed)

A correlation analysis demonstrates that each of these items factors into patients' overall satisfaction with their care and future loyalty behaviors, particularly "likelihood to recommend," which is a powerful measure of future behavioral intention, and "word-of-mouth" effects (see Table 1.1). Thus, when patients think back on and judge their experiences at your facility, one of the things they will consider is their experience with the discharge process. *How* they evaluate their discharge experience is determined by the four factors above. If you wish to create a patient-centered discharge process, build your changes on these critical leverage points.

**1.1** TABLE

## Correlation analysis of the discharge section

Correlation analysis of the discharge section of the survey with overall satisfaction and patient loyalty as measured by "Likelihood to recommend . . . "

| **Based on responses received in 2004 from 2,178,609 patients treated at 1,506 facilities.** | Likelihood of your recommending hospital | Overall rating of care given at hospital |
|---|---|---|
| Extent to which felt ready to be discharged | 0.434 | 0.422 |
| Speed of discharge process | 0.455 | 0.442 |
| Instructions about how to care for self at home | 0.519 | 0.545 |
| Help with arranging home care services | 0.524 | 0.541 |

More than 1,500 hospitals nationwide currently incorporate these questions into their continuous quality measurement and improvement processes. From working with our partners on these issues, we see that patient satisfaction scores for these questions fluctuate as a direct result of improvement interventions, staffing levels, and other management and quality changes. They are true indicators of service quality delivered by everyone involved in the discharge process, including the internal service quality from support functions. Conversely, we also see instances of scores not changing when nothing is done to actually change the patient's reality in the discharge process. One of our favorite proverbs is "You can't fatten the cow by weighing it." That is, management discussion alone—no matter how heated—does not change daily practice on the front lines. Measurement alone does nothing; one must take action. Therefore, use your facility's quantitative and qualitative patient data to make changes in the services and process. The stories and practices we relate here are all examples of some person—typically a mid-level manager or director—taking action with his or her patient satisfaction data to change the reality of the patient's journey home.

Note that, according to an analysis of the Press Ganey National Inpatient Database, patients perceive the discharge process as a discrete series of events, exclusive of the main hospital experience. Thus, the four questions within the discharge section are highly interdependent—improving one aspect of the discharge process is highly likely to improve the other discharge items as well. Using multiple interventions simultaneously will enhance the efficacy of many best practices.

## Implications for national public reporting

In 2006, the Centers for Medicare & Medicaid Services (CMS) will launch the national patient perspectives public reporting initiative, Hospital CAHPS: Patient Perspectives on Care (HCAHPS). Participating hospitals will have their patients' evaluations publicly available at the CMS Hospital Compare Web site (*www.hospitalcompare.hhs.gov*). Like the Press Ganey survey, HCAHPS contains a section devoted to the discharge process (see Table 1.2) and focuses on managing at home, instruction, and coordination of care.

We conducted an analysis of the data from HCAHPS trial runs and compared hospitals' performance in the Press Ganey discharge section to the HCAHPS discharge section. Press Ganey's discharge section was a strong, reliable predictor of performance in the HCAHPS discharge section. Given the looming prospects of public reporting, many hospitals consider it strategically important to measure and improve not just HCAHPS measures but their predictors or precursors on the Press Ganey survey as well.

**1.2 TABLE HCAHPS discharge process questions**

**When you left the hospital**

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

- 1 ❒ Own home
- 2 ❒ Someone else's home
- 3 ❒ Another health facility

**If Another, Go to Question 21**

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

- 1 ❒ Yes
- 2 ❒ No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

- 1 ❒ Yes
- 2 ❒ No

## Synergy: Patients, physicians, and hospitals win-win-win

Information provided during discharge helps patients feel more confident in the management of their health.[2] Standard communication, such as "Is there anything you need or want to know?" on the morning of discharge will ensure that the hospital addresses any lingering information needs.[3] Education and information can then be provided and tailored to the patients' and families' expressed needs.

Despite this, patients' feelings of confidence may not last—they may feel well informed at the point of discharge, but this perception may deteriorate over time. Henderson and Zernike found that within one or two weeks after discharge, patients felt substantially less well informed.[4]

This finding underscores the importance of surveying patients soon after discharge (within the first 10 days) as well as the need for follow-up interventions that we will detail in Chapter *5*.

Once home, a patient can use written instructions as a continuous information resource (e.g., they could outline what to do at home, when to resume life activities, symptoms to look out for, and the contact information of someone on the healthcare team). Patients want clear, understandable instructions.[5] In addition, postdischarge telephone follow-up can help address ongoing information needs. Several studies have shown significant increases in patient satisfaction and improved clinical outcomes when members of the healthcare team phone patients within two weeks following discharge.[6] Patients clearly win when their experience translates into better physical outcomes.

One research finding that amazes healthcare professionals is this: Patients who experience longer stays at hospitals are significantly less satisfied—no matter what their diagnosis. The data tells us that, typically, patients want to go home at least as much as the hospital staff want to see them go home. Most salient is the prospect that, by reducing length of stay, facilities can simultaneously achieve higher patient satisfaction and significant cost savings.

Another important convergence that Press Ganey's research has recently discovered is in the arena of *physician satisfaction*. When analyzing the patient's evaluation of the hospital and comparing it to the physician's evaluation of the same hospital, we find that one of the strongest predictors of physician satisfaction with the quality of patient care and the patients' perspective is *discharge*. Despite the vast sociocultural differences between the typical physician and patient, both agree that an effective discharge process is important to their overall evaluation of quality of care.

Finally, because organizational support for service and quality improvement projects result, in large part, from senior executives' perception of the program's payoffs, let's review the financial benefits of patient satisfaction.[7] As a dimension of hospital quality,

> *Discharge is significantly related to earnings per bed ($p < 0.003$). For earnings per bed, the dollar amount associated with a one point gain or loss in satisfaction (e.g., moving from an average rating of "good" = 3 points to "very good" = 4 points) for this dimension of quality is $4980.*[8]

These facts and the powerful bond between overall patient satisfaction and patient loyalty, likelihood to recommend, and measures of financial performance[9] should provide ample justification for dedicating resources to improving the quality of discharge preparation.

## How to use the next four chapters

The following four chapters of this book center on the four areas of discharge planning: readiness, speed, self-care, and follow-up. Each chapter starts with a fishbone diagram that expresses the different events, both with the patient and the hospital, that can cause an unpleasant discharge experience. And because any unpleasant experience may lead to lower patient satisfaction scores, best practices are provided to counter these negative events. These best practices are real protocols used by hospitals across the nation in an effort to raise satisfaction scores.

Each best practice is also ordered by rank and level of evidence. The bolded best practices are those that have been validated by original qualitative research conducted by Press Ganey. A majority of the best-performing or most-improved hospitals utilized these particular practices in improving or maintaining performance. The levels are broken down in Table 1.3.

## 1.3 Levels of evidence for best practices

- **Level I:** Systematic literature review of randomized controlled trials (RCT). The practice has proven by multiple RCTs to improve patient satisfaction. Review searches for the existence of any evidence to the contrary and factors such evidence into consideration.
- **Level II:** RCTs in which at least one study has shown a cause and effect. Limitations usually apply, as RCTs frequently draw on limited populations.
- **Level III:**: Pseudo-randomized, comparative studies with control and comparative studies with historical control. Limitations always apply to the generalizability of these studies.
- **Level IV:** Case series or case study. Usually uncontrolled; therefore, cause and effect cannot be assumed. Practice used, possibly as part of a cadre of interventions. Holds only the potential for efficacy. Serious limitations on generalizability.
- **Level V:** Unpublished studies of interventions to improve patient satisfaction. Usually not controlled. Almost always one component of several interventions or an overarching organizational change. Cause and effect cannot be determined.

Read a full explanation of how Press Ganey categorizes its best practices in Appendix B.

When resources and finances are limited, it's important to focus on improvements that will offer the best advantage of your facility. These levels will help you to make a more informed decision about which practices your facility might choose to pursue.

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